U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 27 April 2006

Case No. 2004-BLA-5255

In the Matter of:
BASZELLA CHILDERS, Widow of
VERNON CHILDERS,
Claimant,

v.

BETH ENERGY MINES, INC.,
Employer,

Self-Insured through:
BETHLEHEM STEEL CORP.,
c/o ACORDIA EMPLOYERS SERVICE,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-In-Interest.

APPEARANCES:
Mr. William Lawrence Roberts, Esq.
Pikeville, Kentucky
For the Claimant

Ms. Natalee Gilmore, Esq.
Lexington, Kentucky
For the Employer

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of

the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

A formal hearing on this matter was conducted on October 27, 2004, in Pikeville, Kentucky, by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call witnesses, to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above-referenced regulations.

ISSUES[2]

The issues in this case are:

1. Whether the miner had pneumoconiosis as defined by the Act and the regulations;

2. Whether the miner's pneumoconiosis arose out of his coal mine employment;

3. Whether the miner's disability or death was due to pneumoconiosis;

4. Whether Claimant has dependents for purposes of augmentation; and

5. Whether Claimant is an eligible survivor of the miner.

(DX 47; Tr. 12).[3]

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background

Mr. Vernon Childers was born on October 1, 1930. (DX 1). He died on June 24, 2001. (DX 12). The record reflects seventeen years of coal mine employment. (DX 1, 4, 7). Mr.

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[1] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000) (to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[2] At the hearing, the following issues were withdrawn: (1) timeliness, (2) Claimant's status as a miner, (3) whether the Claimant worked as a miner after December 31, 1969, (4) the length of Claimant's coal mine employment, and (5) whether Claimant's most recent period of cumulative employment of not less than one year was with the named Responsible Operator. (DX 40, Tr. 11). Finally, Employer listed other issues that will not be decided by the undersigned; however, they are preserved for appeal. (Item 18(B), DX 40).

[3] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

Childers and Mrs. Baszella Childers (Claimant) married in Clintwood, Virginia, on June 2, 1951. (DX 1, 11; Tr. 15). At the time of Mr. Childers' death, the couple had been married for fifty years. (DX 12; Tr. 15). They did not have any dependent children at the time of Mr. Childers' death. (DX 1, 3). Claimant has not remarried. (Tr. 16).

Claimant testified that Mr. Childers was a construction worker and a coal miner. (Tr. 15). He did coal mining for seventeen years. (Tr. 15). When Mr. Childers came home from work, he was greasy and dusty. (Tr. 16). She testified that Dr. Donald Gibson had been Mr. Childers' treating physician for nearly twenty years. (Tr. 16). Dr. Broudy treated Mr. Childers on one occasion. (Tr. 16-17). Claimant testified that Mr. Childers smoked for approximately two years while he was in the military. (Tr. 17, 19). Mr. Childers was also treated for a heart condition. (Tr. 20). He had problems with his heart in 1982. (Tr. 21). Claimant testified that a heart attack caused Mr. Childers' death. (Tr. 21).

While working, Mr. Childers was not permitted to wear a respirator. (DX 5). After work, his throat sometimes bothered him and he spit and coughed. (DX 5). Mr. Childers was required to lift heavy things. (DX 5). Mr. Childers' breathing was bad. (DX 6). He also had problems walking and going up and down stairs. (DX 6).

Procedural History

Mr. Childers filed his original claim for benefits on October 7, 1985. (DX 1). The Director, Office of Workers' Compensation (OWCP), denied the claim on March 18, 1986, because he failed to prove the existence of pneumoconiosis, that his alleged pneumoconiosis arose out of his coal mine employment, or that he was totally disabled due to pneumoconiosis. (DX 1). On May 10, 1988, the claim was referred to the Office of Administrative Law Judges (OALJ) for a formal hearing. (DX 1). Administrative Law Judge Charles W. Campbell issued a Decision and Order Denying Benefits on August 22, 1990. (DX 1). Judge Campbell determined that Mr. Childers established the existence of pneumoconiosis and that his pneumoconiosis arose from his coal mine employment. (DX 1). Mr. Childers, however, failed to show the presence of total disability as defined in § 718.204(b). (DX 1). Mr. Childers appealed, and the Benefits Review Board (BRB) affirmed Judge Campbell's Decision and Order on September 1, 1992. (DX 1).

Mr. Childers made a request for Modification on September 11, 1992. (DX 1). The Director, OWCP, denied the request for Modification on August 16, 1993, because there was no change in conditions and no mistake in determination of fact. (DX 1). The claim was referred to the OALJ on November 16, 1993. (DX 1). On February 27, 1995, Judge Gerald M. Tierney issued a Decision and Order Denying Benefits because the new evidence did not establish the requisite element of total disability due to pneumoconiosis. (DX 1). The BRB issued a Decision and Order on September 28, 1995, affirming Judge Tierney's denial of benefits. (DX 1).

On May 9, 1996, Mr. Childers requested Modification. (DX 1). The Director, OWCP, denied Mr. Childers' request for Modification on August 14, 1996, because there was neither a material change in condition nor a mistake in determination of fact. (DX 1). The claim was referred to the OALJ on November 22, 1996, for a formal hearing. (DX 1). Judge Michael

O'Neill issued a Decision and Order Denying Benefits on August 5, 1998. (DX 1). He found that Mr. Childers failed to establish total disability. (DX 1). On January 31, 2000, the BRB affirmed. (DX 1).

Claimant filed her survivor's claim on December 19, 2001. (DX 3). On August 6, 2003, the Director, OWCP, issued a Proposed Decision and Order awarding benefits. (DX 38). The Director determined that Mr. Childers suffered from pneumoconiosis and that pneumoconiosis caused his death. (DX 38). On August 14, 2003, Beth Energy Mines, Inc., (Employer) requested a formal hearing before the OALJ. (DX 39). The claim was referred to the OALJ on November 13, 2003. (DX 47).

MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. Claimant and Employer are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, no more than one report of each autopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy reports, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by Claimant under § 725.414. § 725.406(b).

Mr. Childers was deceased when this survivor's claim was initiated. Therefore, the Department did not sponsor a complete pulmonary examination with regard to the survivor's claim.

Claimant completed a Black Lung Benefits Act Evidence Summary Form. (CX 6). Claimant designated two chest x-rays dated September 11, 1988, and February 13, 1990. (CX 6). These were interpreted by Dr. Fisher on February 1, 1990, and Dr. Mathur on March 21, 1990, respectively. (DX1). This evidence is admitted because it complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414 (a)(2)(i).

For autopsy evidence, Claimant submitted the reports by Dr. Dennis dated August 20, 2001, May 9, 2003, and October 1, 2004 (DX 13; CX 1, 2). I find that the latter two reports supplement Dr. Dennis' original autopsy report dated August 20, 2001. This evidence is,

therefore, admitted because it complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414 (a)(2)(i).

Claimant designated the following exhibits as both medical reports and hospitalization records/treatment notes: DX 20, DX 18, DX 16, DX 14, CX 1, CX 3, and CX 4. The following records are contained in DX 20[4]: Dr. Broudy's June 5, 2001, treatment notes; Dr. Ammisetty's November 21, 2000, treatment notes; Dr. Ammisetty's December 5, 2000, treatment notes; Dr. Gibson's handwritten treatment notes from 1982 to 2001; Dr. Balthrop's November 18, 1999, progress note[5]; Dr. Malik's January 19, 1997, consultation report including electrocardiogram (EKG); and Dr. Gibson's medical report and treatment plan from Mr. Childers' February 23, 1997, hospital visit. Dr. Gibson's medical report dated March 9, 2003, is contained in DX 18. Dr. Gibson's medical report dated September 18, 2002, is contained in DX 16. The following records are contained in DX 14: Dr. Gibson's letter to William Roberts, Esq., dated September 5, 1997; Dr. Clarke's July 24, 1992, medical report including chest x-ray, pulmonary function test, and arterial blood gas study; Dr. Fritzhand's February 28, 1996, medical report including pulmonary function test, arterial blood gas study, and EKG; Dr. Smith's January 18, 1997, emergency room report; Dr. Broudy's June 5, 2001 treatment notes; and Dr. Gibson's August 30, 1994, letter addressed to "To Whom It May Concern." Dr. Broudy's letter dated July 17, 2003, is contained in CX 1. Dr. Gibson's letter dated October 8, 2004, addressed to "To Whom It May Concern" is contained in CX 3. Finally, CX 4 contains Dr. Gibson's handwritten treatment notes from 1982 to 2001.[6]

Claimant is only permitted to submit two medical reports in support of her position, yet she has listed seven different exhibits with some exhibits containing multiple reports from multiple physicians. After reviewing all the relevant exhibits, I find that there are seven different medical reports, as defined by 20 C.F.R. § 725.414(a)(1), contained herein: Dr. Gibson's reports dated August 30, 1994 (DX 14); September 5, 1997 (DX 14); September 18, 2002 (DX 16), March 9, 2003 (DX 18), and October 8, 2004 (CX 3); Dr. Clarke's July 24, 1992, report (DX 14); and Dr. Fritzhand's February 28,1996, report (DX 14). I find Dr. Gibson's letter dated October 8, 2004, to be inadmissible because Dr. Gibson referred to records that may be outside the evidentiary record.[7] I will consider Dr. Gibson's remaining reports together because they supplement one another. Claimant, therefore, is permitted to designate one other medical report. There are, however, two other reports to consider, those of Drs. Clarke and Fritzhand. Based on her Evidence Summary Form, Claimant clearly wanted me to consider Dr. Gibson's reports as part of her initial evidence.[8] It would be arbitrary and capricious for me to choose one of these remaining reports over the other. Compounding the problem is the fact that these two reports include chest x-ray, pulmonary function tests, and arterial blood gas studies, which constitutes

[4] Director's Exhibit 20 contains 75 pages of medical reports, hospitalization records, and treatment notes completed by various physicians. On her summary form, Claimant designated DX 20 "Dr. Gibson." Therefore, I will only consider those reports, records, and notes made by Dr. Gibson.

[5] Progress note is related to Mr. Childers' knee pain.

[6] This is a copy of Dr. Gibson's handwritten treatment notes contained in DX 20.

[7] Dr. Gibson wrote, "I received records from the attorney of Baszella Childers, widow of Vernon Childers, which I have reviewed." He did not reference which records were reviewed. Hence, I cannot consider his opinion because the underlying records may be outside the evidentiary record of this claim.

[8] Despite the clear requirement to designate only two reports, Claimant listed all seven exhibits but only listed Dr. Gibson under the heading for "Physician."

underlying evidence that Claimant did not designate for consideration. As such, these reports would be disregarded anyway because both doctors relied on evidence that is outside of the evidentiary record in forming their conclusions. Therefore, I find that the medical reports of Drs. Clarke and Fritzhand exceed the limitations of § 725.414 (a)(2)(i) and may not be considered. I further cannot admit Dr. Broudy's letter dated July 17, 2003, found at CX 1 because it exceeds the evidentiary limitations for medical reports and is neither a hospital record nor a treatment note. I admit the remaining items in exhibits DX 20, DX 14, and CX 4 for consideration as hospitalization records/treatment notes pursuant to 20 C.F.R. § 725.414(a)(4). To summarize, I find the following reports inadmissible: Dr. Gibson at CX 3, Dr. Clarke at DX 14, Dr. Fritzhand at DX 14, and Dr. Broudy at CX 1. The remainder of Claimant's medical reports submitted as initial evidence is admissible because it complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414 (a)(2)(i).

Employer submitted an evidentiary summary form. (EX 11). As its initial evidence, Employer designated two readings of the June 5, 2001, chest x-ray by Drs. Wiot and Spitz on March 7, 2003, and September 17, 2004, respectively. (DX 19; EX 5). Employer submitted one arterial blood gas study dated June 5, 2001. (DX 20). Employer designated Dr. Caffrey's autopsy report dated March 4, 2003, and subsequent deposition in its initial evidence. (DX 17; EX 9). Although Dr. Caffrey considered a report by Dr. Clarke that was dated July 24, 1992, that is outside the evidentiary record, I find that it can be severed because it had no bearing on Dr. Caffrey's review of the autopsy slides and final opinions regarding the existence of pneumoconiosis and the cause of Mr. Childers' death. See *Webber v. Peabody Coal Co.*, 23 B.L.R. 1-___, BRB No. 05-0335 BLA (Jan. 27, 2006) (*en banc*). I have considered Dr. Caffrey's deposition in conjunction to his medical report because it supplements his original report.[9] Employer submitted two medical reports for consideration: Dr. Broudy's report dated March 10, 2003, and subsequent deposition, and Dr. Jarobe's report dated August 29, 2004, and subsequent deposition. (DX 17; EX 7, 3, 8). I have determined, however, that these medical reports and depositions are inadmissible because both physicians considered medical evidence that is outside the record in forming their opinions and conclusions.[10] The amended regulations provide that physicians rendering medical opinions may not consider evidence that has not been admitted into the record. 20 C.F.R. §§ 725.427(d) and 725.458 (2001). Employer also requested consideration of various hospitalization records and treatment notes by Dr. Broudy on June 5, 2001; Dr. Ammisetty on December 5, 2000; Dr. Gibson on February 23, 1997; and Pikeville Medical Hospital records from Mr. Childers' admissions on June 29, 1982, July 26, 1988, January 17, 1989, and March 28, 1991. (DX 20, 21). These documents are properly submitted as hospitalization records and treatment notes. With the exception of Dr. Broudy's medical report dated March 10, 2003, and Dr. Jarobe's medical report dated August 9, 2004, I find that Employer's initial evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3)(i) and is, therefore, admitted.

[9] § 725.414(c).

[10] Specifically, Dr. Broudy reviewed Dr. Clarke's medical report dated July 24, 1992, and Dr. Fritzhand's medical report dated February 28,1996. Dr. Jarobe reviewed Dr. Clarke's medical report dated July 24, 1992; Dr. Fritzhand's medical report dated February 28,1996; and Dr. Broudy's medical report dated March 10, 2003. These items have not been admitted into evidence. Hence, these reports cannot be considered.

Claimant offered no rehabilitative or rebuttal chest x-ray evidence. (CX 6). As rehabilitative evidence, Claimant identified Dr. Baker's report dated October 11, 2004. (CX 5). The regulations allow rehabilitative evidence only from the physician who prepared the original medical report. In this case, Claimant submitted Dr. Gibson's medical reports yet offered rehabilitative evidence by Dr. Baker. This violates 20 C.F.R. § 725.414(a)(2)(ii) and cannot be considered as rehabilitative evidence.

In rebuttal to Employer's autopsy evidence, Claimant offered Dr. DeLara's medical report dated October 11, 2001. (DX 15). Claimant's rebuttal evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414 (a)(2)(ii). Therefore, I admit these pieces of evidence designated in Claimant's summary form.

Employer offered no rehabilitative or rebuttal chest x-ray evidence. (EX 11). To rebut Dr. Dennis' autopsy report dated August 20, 2001, Employer designated Dr. Crouch's report dated August 12, 2004, and subsequent deposition. (EX 2, 6). I will consider these items together because Dr. Crouch's deposition supplements his medical report. Dr. Crouch considered "miscellaneous medical records regarding Mr. Vernon Childers." However, Dr. Crouch made his own independent assessment of the autopsy slides. Based on Dr. Crouch's comments, it appears that the only records he reviewed were the admissible autopsy reports of Drs. Dennis and DeLara. Employer's rebuttal evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414 (a)(3)(ii). Therefore, I admit this rebuttal evidence designated in Claimant's summary form.[11]

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[11] In *Kalist v. Buckeye Coal Co.*, BRB No. 03-0743 BLA (July 23, 2004) (unpub.), the Board cited to 20 C.F.R. § 718.106(a) and adopted the Director's position that only the original prosector's report is considered a "report of autopsy" for purposes of the evidentiary limitations at 20 C.F.R. § 725.414 (2004). In so holding, the Board noted that the Director argued that "[w]hile highly unlikely, . . . it is possible that more than one physician may conduct an examination of the body *post mortem*; therefore, it is possible that more than one report of an autopsy may be prepared." As a result, the Board held that the prosector's report would be admitted as the "autopsy" report of record by Claimant and an additional report reviewing the prosector's report and slides from Claimant was permitted to be admitted as one of her two medical opinion reports.

If the ruling from *Kalist* is applied to the designations in the instant claim, Dr. Dennis's autopsy report and Dr. Crouch's rebuttal would be the only evidence admitted in this claim. This is because under *Kalist*, Dr. Caffrey's report would not constitute an "autopsy report," and thus, Dr. Delara would not be able to submit a rebuttal. As a result, both reports would be excluded because they would exceed the limitations of §725.414(a)(2). I note, however, that *Kalist* is unpublished, and as a result, I have admitted Dr. Caffrey's autopsy slide review as Employer's autopsy evidence. As a result, Dr. Delara's evidence is also admissible as Claimant's rebuttal evidence.

Even if I had not admitted Dr. Caffrey's report as initial autopsy evidence, due to the fact that I have excluded both of Employer's medical reports as initial evidence, Dr. Caffrey's report could fill one of the slots vacated by Dr. Jarboe's or Dr. Broudy's reports, and is thus admissible under the limitations of §725.414. Likewise, due to the fact that I was unable to pick which of Claimant's medical reports to consider, and thus, excluded both Dr. Clarke's and Dr. Fritzhand's opinions, Claimant is now left with a slot in which to fit Dr. Delara's opinion as a medical report. Therefore, even applying the ruling from *Kalist*, I find that all four of the pathology reports submitted in this claim are admissible.

In closing, I note that the most difficult aspect of this claim was reconciling the parties' evidentiary designations with the limitations found in §725.414. These limitations are not optional. *See, e.g., Smith v. Martin County Coal Corp.*, 23 B.L.R. 1-__, BRB No. 04-0126 BLA (Oct. 27, 2004) ("the parties must present their evidence as delineated in Section 725.414"); *Gilbert v. Consolidation Coal Co.*, BRB Nos. 04-0672 BLA and 04-

X-RAY REPORTS

Exhibit	Date of X-ray	Date of Reading	Physician/Qualifications	Interpretation
DX 1[12]	09/14/89	02/01/90	Fisher, BCR, B-reader	2/1
DX 1[13]	02/13/90	03/21/90	Mathur, BCR, B-reader	1/2
DX 19	06/05/01	03/07/03	Wiot, BCR, B-reader	Negative
EX 5	06/05/01	09/17/04	Spitz, BCR, B-reader	Negative

PULMONARY FUNCTION STUDIES

The parties did not designate any pulmonary function studies.

ARTERIAL BLOOD GAS STUDIES

Exhibit	Date	pCO_2	pO_2	Qualifying
DX 20	06/05/01	33.5	83.9	No

Medical Reports

Dr. K. D. Gibson, D.O. (DX 14, 16, 18)

Dr. Gibson's August 30, 1994, letter is addressed to "To Whom It May Concern." Dr. Gibson states that Mr. Childers suffered from work-related coal pneumoconiosis and was undergoing treatment. He mentioned that Mr. Childers also suffered from diabetes mellitus, coronary artery disease, and hypertension. The remainder of the letter addresses Mr. Childers' disability, which is not relevant to this claim.

Dr. Gibson drafted a letter to Mr. William Roberts, Esq., on September 5, 1997. It stated that he treated Mr. Childers on a regular basis since 1982. Dr. Gibson stated, "my patient, Mr. Vernon Childers [sic] suffers greatly with coal-related pneumoconiosis, COPD, diabetes mellitus, arteriosclerotic vascular disease, hypertension, hyperlipidemia, arthritis, and chronic

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0672 BLA-A (May 31, 2005) (*unpub.*) (holding that the evidentiary limitations set forth at §725.414 are mandatory and, absent a finding of "good cause," it was proper for the ALJ to exclude the deposition testimony offered by Employer of Claimant's treating physician). In all, a total of seven Claimant's and Employer's medical reports were excluded from the record for one reason or another. In addition, applying *Kalist*, I would be forced to move evidence from one designation section to another simply to avoid having additional highly relevant evidence excluded from consideration. Under the "new," mandatory regulations of January 1, 2001, governing the limitations of medical evidence; the burden is on the respective parties to insure that their evidence clearly fits within each of the categories of admissible evidence. In order to then insure that the "good cause" exception is properly analyzed, it is my opinion that it must then be invoked and justified by the party seeking the exception.

[12] This is marked as DX 55 in the living miner's original claim.
[13] This is marked as DX 59 in the living miner's original claim.

angina." The remainder of the letter addresses the extent of Mr. Childers' disability, which is not relevant in this claim.

Dr. Gibson treated Mr. Childers from November 1982 to April 2001. He completed a supplemental questionnaire on September 18, 2002, regarding Mr. Childers' condition. Dr. Gibson determined that Mr. Childers suffered from an occupational lung disease caused by his coal mine employment. He based this diagnosis on "years of treatment for lung disease without any other cause of lung disease except dust exposure" without considering chest x-rays. Dr. Gibson opined that pneumoconiosis contributed to or played a hastening role in Mr. Childers' death. He stated, "Lung disease caused increased stress on heart and accelerated death."

Dr. Gibson submitted another supplemental questionnaire on March 9, 2003. He opined that Mr. Childers had an occupational lung disease caused by his coal mine employment. He based this diagnosis on Mr. Childers' prior records, chest x-ray results, and physical examination. Dr. Gibson determined that 70% of Mr. Childers' lung disease was due to coal dust exposure and 30% was due to smoking. He concluded that pneumoconiosis contributed to or hastened death because Mr. Childers' respiratory distress increased the work load on his heart that resulted in cardiac death. Dr. Gibson prescribed oxygen to Mr. Childers before his demise due to shortness of breath and low oxygen saturation.

Autopsy Reports

Dr. James A. Dennis (DX 13; CX 1, 2)

Dr. Dennis is a pathologist who issued the Autopsy Report and Final Diagnosis of Mr. Childers. He provided a gross description and a microscopic description of Mr. Childers' heart and lungs. Dr. Dennis found black pigment deposition outlining the lung, but there was only a very small amount of black pigment available for evaluation.

Dr. Dennis dissected the lung into sections and submitted portions in Cassettes "A" through "J." On gross examination, he found congestion, "no to minimal" black pigment deposition, and "no to minimal" fibrosis. On microscopic examination, Dr. Dennis noted congestion, edema, focal bronchopneumonia, inflammation, minimal black pigment deposition, and very little fibrosis. Dr. Dennis diagnosis with regard to Mr. Childers' respiratory system was (1) pulmonary congestion and edema moderate to severe, (2) minimal black pigment deposition with very little fibrosis, and (3) focal bronchopneumonia. With regard to Mr. Childers' cardiovascular system, Dr. Dennis diagnosed, (1) left ventricular hypertrophy, (2) hypertensive cardiovascular disease, and (3) coronary artery disease, moderate to severe. Dr. Dennis summarized his findings by stating, "This patient died as a result of coronary artery disease, hypertensive cardiovascular disease with pulmonary congestion, and edema. Clinical correlation is recommended. Minimal evidence of black lung disease is noted in this patient."

Dr. Dennis submitted a supplemental questionnaire on May 9, 2003. He concluded that Mr. Childers had an occupational lung disease caused by his coal mine employment. Dr. Dennis based his opinion on his autopsy findings. Dr. Dennis determined that a direct cause and effect relationship existed between Mr. Childers' respiratory condition and dust exposure in coal mine

employment. He also wrote what appears to be "minimal arthrosilicosis." Dr. Dennis opined that pneumoconiosis contributed to or played a hastening role in Mr. Childers' death.

Dr. Dennis submitted a supplemental questionnaire on October 1, 2004. He opined that Mr. Childers had a chronic lung disease that was caused by his coal mine employment. The questionnaire asked for Dr. Dennis to provide the basis for the diagnosis as either "clinical pneumoconiosis" and/or "legal pneumoconiosis" and provided space to elaborate as to the basis of such diagnosis. However, Dr. Dennis failed to check "clinical pneumoconiosis" or "legal pneumoconiosis" and instead drew and checked-in his own box in the space provided for elaboration and simply wrote "autopsy." When asked if he diagnosed the presence of pneumoconiosis on the basis of chest x-ray or treatment, Dr. Dennis responded with, "Neither—autopsy." He found that Mr. Childers' had a respiratory disease and enhancement of severity due to coal dust exposure. Dr. Dennis determined that only part of Mr. Childers' chronic lung disease was causally related to the inhalation of coal mine dust. In fact, he found that only 5% of Mr. Childers' chronic lung disease was due to coal dust exposure. He determined that the rest of Mr. Childers' chronic lung disease was caused by emphysema (5%), chronic obstructive pulmonary disease (35-40%), and coronary artery disease with pulmonary edema (40%). Dr. Dennis concluded that pneumoconiosis contributed to or played a hastening role in Mr. Childers' death. His rationale was that severe lung disease with coal dust exposure contributed to hyposis.

Dr. Carlos F. DeLara, M.D. (DX 15)

Dr. DeLara submitted an autopsy report dated October 11, 2001. He received and reviewed fourteen slides from Pikeville Methodist Hospital from Mr. Childers' autopsy. His report states:

> The slides from the lungs showed deposits of black anthracotic pigments subpleurally, around blood vessels, bronchioles and alveolar septae. Mild reactive fibrosis are [*sic*] present to form macules. Central emphysematous changes are present and together with the coal macules would qualify Mr. Childers to have Simple Coal Workers' Pneumoconiosis.
>
> Mr. Childers [*sic*] pulmonary problems was [*sic*] contributory to many of his medical disability [*sic*]. I hope this will help Mr. Childers [*sic*] family to get what they deserve.

Dr. P. Raphael Caffrey, M.D. (DX 17, EX 9)

Dr. Caffrey, a Board-certified pathologist who specializes in pulmonary pathology, submitted a consultation report dated March 4, 2003. He reviewed Claimant's claim for benefits dated December 19, 2001; multiple records from Methodist Hospital of Pikeville, Kentucky, from 1982, 1988, 1989, 1991, and 1997; Dr. Ammisetty's treatment notes dated November 21, 2000, and December 5, 2000; Dr. Broudy's treatment notes dated June 5, 2001; Dr. Clarke's medical report dated July 24, 1992[14]; Dr. Gibson's medical reports dated August 30, 1994, and

[14] This report has been severed from Dr. Caffrey's opinions regarding Mr. Childers' autopsy findings.

September 5, 1997; Dr. DeLara's autopsy report dated October 11, 2001; a chest x-ray dated January 18, 1997; Mr. Childers' death certificate dated June 24, 2001; the Dr. Dennis' autopsy report dated June 24, 2001; and fourteen slides from Mr. Childers' autopsy.

His review of the left lung showed only a minimal amount of anthracotic pigment noted mostly around blood vessels. He found no evidence of lesions of coal workers' pneumoconiosis in the left lung. In the right lung, Dr. Caffrey found a mild to moderate amount of edema fluid with only a minimal amount of anthracotic pigment noted subpleurally. There was no evidence of the lesions of coal workers' pneumoconiosis or simple silicosis on the slides. Dr. Caffrey did not find any evidence of pulmonary fibrosis on the slides from either the right or the left lungs. His final diagnosis for Mr. Childers' cardiovascular system was (1) cardiomegaly—712 grams, and (2) moderately severe coronary artery atherosclerosis. Dr. Caffrey's final diagnosis for Mr. Childers' respiratory system was (1) moderately severe pulmonary edema; (2) chronic bronchitis, mild; (3) centrilobular emphysema, mild; and (4) minimal amount of anthracotic pigment identified within lung tissue and adjacent lymph node tissue.

Dr. Caffrey opined that Mr. Childers did not have coal workers' pneumoconiosis or silicosis. He further concluded that coal workers' pneumoconiosis did not contribute to or hasten Mr. Childers' death.

At his deposition on October 14, 2004, Dr. Caffrey discussed the requirements for finding coal workers' pneumoconiosis via autopsy. Using the pathology standards for coal workers' pneumoconiosis published in the Archives of Pathology and Laboratory Medicine in July 1979, Dr. Caffrey stated that the characteristic lesion of coal workers' pneumoconiosis is a focal collection of coal dust-ladened macrophages at the division of respiratory bronchioles that may exist within alveoli and extend into the peribronchiolar interstitium with associated reticulin deposits and focal emphysema. In layman's terms, the anthracotic pigment or coal dust must stimulate the production of reticulin or connective tissue and usually, but not always, causes focal emphysema. Dr. Caffrey reviewed the autopsy slides and felt that he was in the same position as Dr. Dennis in making his diagnosis. He stated, "anyone who is properly trained can look at the [autopsy] slides and they should essentially arrive at the same diagnosis."

Dr. Caffrey explained each of his diagnoses. He described pulmonary edema as fluid on the lungs. He stated that pulmonary edema causes trouble breathing but is not caused by coal dust exposure. Dr. Caffrey explained that chronic bronchitis is inflammation of the bronchi. It can be caused by coal dust exposure, local irritants breathed in from the air, and cigarette smoke. Dr. Caffrey doubted that this caused any significant disability in Mr. Childers. He did not feel that coal dust exposure caused Mr. Childers chronic bronchitis because there was only a minimal amount of anthracotic pigment present in his lungs. Dr. Caffrey described centrilobular emphysema as alveoli that gets distended and loses its elasticity. This causes a decreased ability to take in oxygen and to get rid of carbon dioxide. Dr. Caffrey felt that Mr. Childers' mild degree of centrilobular emphysema was not disabling and was not caused by coal dust exposure.

Dr. Caffrey did not find evidence of coal workers' pneumoconiosis on the slides. He found anthracotic pigment but not the lesions of simple coal workers' pneumoconiosis. Dr. Caffrey opined that the minimal amount of anthracotic pigment in the lung sections was not

sufficient for a finding of coal workers' pneumoconiosis, and even if it was sufficient for such finding, it "certainly would not have been disabling" to Mr. Childers.

Dr. Caffrey concluded that there was no evidence that coal workers' pneumoconiosis caused, contributed to, or hastened Mr. Childers' death because the minimal amount of anthracotic pigment would not have disabled him. He found that Mr. Childers had significant medical problems that were unrelated to his coal mine employment or coal dust exposure.

On cross-examination, Dr. Caffrey stated that chronic bronchitis, which he said was mild and centrilobular emphysema, could be due to smoking or to coal dust. He admitted that his diagnosis of "minimal amount of anthracotic pigment" was certainly due to coal dust. Dr. Caffrey said that inhalation of coal dust could not cause fluid in the lungs. He felt that diffuse simple coal workers' pneumoconiosis or complicated coal workers' pneumoconiosis involving both lungs could cause hypoxia and possibly cardiac arrest. He admitted that if the lung disease were severe enough it could cause a patient's heart to work harder.

On redirect examination, Dr. Caffrey opined that Mr. Childers did not have bad lungs. He noted that Mr. Childers had marked pulmonary edema due to his cardiac condition. He opined that coal dust exposure did not contribute to Mr. Childers' cardiac arrest.

Dr. Erika C. Crouch, M.D., Ph.D. (EX 2, 6)

Dr. Crouch, a Board-certified anatomic pathologist, submitted a report dated August 12, 2004. She reviewed fourteen slides from the autopsy, the autopsy report, Mr. Childers' death certificate, and miscellaneous medical records. Dr. Crouch noted that nine of the fourteen slides contained sections of pulmonary tissue. She reported,

> The lung shows areas of collapsed or uninflated parenchyma but no other significant abnormality. There is very mild deposition of irregular black to dark brown particles consistent with coal dust. Polarization microscopy also reveals amounts of short needle-like particles consistent with silicates. No coal dust macules, micronodules, nodules or larger lesions are identified. No silicotic lesions are observed. There is no significant emphysema.

Dr. Crouch diagnosed minimal coal dust deposition with no evidence of pneumoconiosis. She remarked that there was a small amount of coal dust within the lung but no evidence of pneumoconiosis. There were no minimal macular lesions, nor was there any evidence of emphysema. Dr. Crouch opined that occupational dust exposure could not have caused any degree of impairment or disability. She further concluded that occupational dust exposure could not have caused, contributed to, or otherwise hastened Mr. Childers' death. Dr. Crouch's microscopic findings were consistent with the gross autopsy report, which failed to identify macules or other dust-related abnormalities. She agreed with Dr. Dennis' diagnosis of minimal black pigment deposition with very little fibrosis, but she disagreed with his diagnosis of pneumoconiosis. She also disagreed with Dr. DeLara's opinion.

At her deposition on September 29, 2004, Dr. Crouch described what you have to see to diagnose coal workers' pneumoconiosis pathologically. The minimal lesion is a coal dust macule in the lungs. The appearance of these lesions tends to correlate with the levels of exposure. She reviewed nine slides of pulmonary tissue from Mr. Childers' autopsy. Dr. Crouch did not see any changes consistent with coal workers' pneumoconiosis. She noted that there was coal dust in the lung tissue but there were no coal dust macules or changes of focal emphysema. Dr. Crouch indicated that everyone believed that there was coal dust in the lungs. The issue was how the lung reacted to the dust. She found no evidence of the lung structure being altered from the coal dust and, therefore, no coal workers' pneumoconiosis. Because she found no evidence of coal workers' pneumoconiosis, it could not have caused, contributed to, or hastened Mr. Childers' death. Even if Dr. Crouch interpreted Dr. Dennis' finding of "minimal black lung disease" to mean pneumoconiosis, she felt that the changes in the lung were so mild that it could not have caused his disease or contributed to his death.

On cross examination, Dr. Crouch stated that an individual's severe lung condition could cause his heart to work harder and to cause a heart attack.

During her redirect examination, Dr. Crouch found that Mr. Childers' did not have a heart attack because of a severe lung condition.

Hospitalization Records and Treatment Notes

Dr. Gibson's handwritten treatment notes from 1982 to 2001 were submitted for consideration. (DX 20, CX 4). He treated Mr. Childers on the following dates: November 17, 1982; December 28, 1989; October 11, 1991; November 4, 1991; November 12, 1991; September 27, 1991; September 8, 1992; December 8, 1992; January 21, 1993; August 2, 1993; September 2, 1993; October 12, 1993; June 4, 1993; November 30, 1993; February 18, 1994; May 17, 1994; May 23, 1994; June 6, 1994; November 15, 1994; December 19, 1994; April 20, 1995; June 1, 1995; July 3, 1995; August 1, 1995; October 9, 1995; October 12, 1995; January 4, 1996; May 5, 1996; July 12, 1996; August 8, 1996; September 10, 1996; March 28, 1996; March 29, 1996; June 17, 1996; September 19, 1996; October 3, 1996; December 3, 1996; February 25, 1997; March 4, 1997; May 20, 1997; May 22, 1997; August 11, 1997; August 15, 1997; August 28, 1997; October 14, 1997; November 3, 1997; November 4, 1997; December 22, 1997; January 6, 1998; January 26, 1998; February 5, 1998; April 20, 1998; April 21, 1998; May 11, 1998; June 8, 1998; July 13, 1998; July 14, 1998; October 5, 1998; December 28, 1998; December 29, 1998; March 22, 1999; March 23, 1999; May 3, 1999; May 10, 1999; July 8, 1999; August 30, 1999; June 12, 1999; September 7, 1999; September 9, 1999; October 7, 1999; November 4, 1999; November 30, 1999; December 3, 1999; February 22, 2000; February 24, 2000; May 16, 2000; June 26, 2000; July 17, 2000; August 8, 2000; August 10, 2000; August 14, 2000; August 28, 2000; October 31, 2000; November 3, 2000; December 22, 2000; December 28, 2000; January 18, 2001; February 15, 2001; April 4, 2001; and April 30, 2001. These office visits were for general cardiac check-ups, and treatment of flu, colds, knee pain, low back pain, a finger injury, and foot pain. He only complained of shortness of breath on one occasion. Dr. Gibson diagnosed chronic obstructive pulmonary disease, hypertension, hypertrophy, ASHD, bronchitis (one time), diabetes, and congestive heart failure.

Mr. Childers was admitted to the hospital on June 29, 1982, and was discharged on June 30, 1982. (DX 21). He experienced chest pain. Dr. Ronald Mann examined Mr. Childers. In Mr. Childers' past medical history, Dr. Mann did not mention any pulmonary disease. On physical examination, the chest was clear. His assessment was "chest pain, etiology to be determined." Dr. K. B. Kim took a chest x-ray and noted no active cardiopulmonary disease except for borderline heart size.

Mr. Childers was admitted to the hospital on July 26, 1988, and was discharged on July 30, 1988. (DX 21). Dr. Ronald Mann discharged Mr. Childers with a diagnosis of chest pain, probably secondary to cholelithiasis, and esophagitis. Dr. A. Malik's performed a physical examination. He noted that Mr. Childers' lungs showed no dullness to percussion. His breath sounds had vesicular, bilateral basilar rales. Dr. Malik's treatment notes suggested that Mr. Childers had chest pain with etiology to be determined. Dr. K.B. Kim performed a chest x-ray. He noted that both lung fields were well-expanded without active cardiopulmonary disease.

Mr. Childers was admitted to the hospital on January 17, 1989, for elective surgery for cholecystectomy. (DX 21). He was discharged on January 21, 1989. His provisional diagnosis was cholelithiasis with a secondary diagnosis of chronic obstructive pulmonary disease. Dr. S. R. Malempati's discharge summary noted that Mr. Childers had a history of chronic obstructive pulmonary disease. Dr. A. Poulos performed a chest x-ray and noted that the lung fields were clear of acute infiltrates.

Mr. Childers was admitted to the hospital on March 28, 1991, for diabetes, tachycardia, and hypertension. (DX 21). He was discharged on April 2, 1991. Dr. Ronald Mann's treatment notes showed the following diagnoses: (1) diabetes, uncontrolled, (2) hypertension, (3) atherosclerotic cardiovascular disease, and (4) hyperlipidemia. Dr. K. D. Gibson issued treatment notes in conjunction with this admission. He noted that Mr. Childers was referred for admission because of a fast heart rate and blood sugar over 500. Dr. Gibson noted the following items in Mr. Childers' past medical history: hypertension, diabetes, atherosclerotic vascular disease, hyperlipidemia, gastritis, and hiatal hernia. Mr. Childers' breathing was unlabored and his lungs were clear to auscultation and percussion. Dr. Gibson's impressions were (1) diabetes mellitus, uncontrolled, (2) tachycardia, (3) hypertension, (4) atherosclerotic vascular disease, (5) hiatal hernia, and (6) hyperlipidemia.

Mr. Childers was admitted to the hospital for chest pain on January 19, 1997. (DX 20). He was discharged in January 22, 1997. Dr. A. Malik consulted. His impressions were probable aortic stenosis, chest pain, and probably coronary artery disease. Dr. Gibson diagnosed: (1) unstable angina, (2) atherosclerotic heart disease, (3) diabetes mellitus, noninsulin dependent, (4) aortic insufficiency, (5) aortic stenosis, (6) mitral insufficiency, (7) arthritis, (8) hypertension, (9) depression, and (10) chronic obstructive pulmonary disease. Dr. Kathleen Smith also treated Mr. Childers during this hospital visit. (DX 14). She noted that he suffered from heart disease, diabetes, chronic obstructive pulmonary disease, hypertension, arthritis, and knee replacement. Her physical examination revealed that Mr. Childers' lungs were clear on auscultation and that he had edema of the lower extremities. She diagnosed atypical chest pain and ruled out myocardial infarction.

Mr. Childers was admitted to the hospital for chest pain on February 23, 1997. (DX 20). Dr. Gibson's physical examination revealed decreased breath sounds in all lung fields with non-labored respirations and no evidence of edema, clubbing, or cyanosis. Dr. Gibson's impressions were chest pain, atherosclerotic heart disease, valvular heart disease, chronic obstructive pulmonary disease, hyperlipidema, hypertension, diabetes mellitus, and anxiety depression.

Dr. John E. Balthrop evaluated Mr. Childers on November 18, 1999, for his knee pain. (DX 20).

Dr. Ammisetty treated Mr. Childers on November 21, 2000, at Dr. Gibson's request for a consultation. (DX 20). Dr. Ammisetty reviewed Mr. Childers' complaints, smoking history, hospitalization, work history, family history, medications, and his systems. Dr. Ammisetty noted that Mr. Childers had a history of cough with slight whitish productive sputum that had been going on for a long time and had worsened. This was associated with wheezing. Mr. Childers complained of dyspnea on exertion with walking two blocks on level ground at a slow pace and climbing more than two or three steps. Mr. Childers also complained of chest pain. He stated that he slept on two pillows at night and often woke up because of difficulty breathing. Dr. Ammisetty reported a smoking history of one pack per day for two years from 1952 to 1954. He noted that Mr. Childers worked in the coal mines until 1985 as a welder and repairer in the underground coal mines. Dr. Ammisetty recorded that Mr. Childers had a history of high blood pressure, heart diseases, and diabetes. Mr. Childers' medications included Transderm nitroglycerin, Trental, Lasix, Lobid, Neurontin, Vioxx, Vistaril, Ambien, Desyrel, Reglan, Ultram, Slo-bid, Prevacid, Capoten, DiaBeta, allopurinol, Zyrtec, Lanoxin, Calan, Lescol, and Bayer Buffered aspirin. On physical examination, Dr. Ammisetty noted that Mr. Childers was slightly short of breath but able to speak full sentences. He found decreased breath sounds throughout all the lung fields and inspiratory rales bibasilar. He diagnosed (1) chronic obstructive pulmonary disease, (2) aortic valvular heart disease, (3) arthritis, status post knee surgery, and (4) coronary artery disease. Dr. Ammisetty determined that Mr. Childers had shortness of breath and dyspnea on exertion. He noted that Mr. Childers' heart was significantly compromised. He ordered tests for further evaluation.

Dr. Ammisetty evaluated Mr. Childers again on December 5, 2000. (DX 20). Mr. Childers had shortness of breath on exertion, no cough, and no sputum production. A pulmonary function test suggested a mild restrictive airway disease, normal DLCO. Mr. Childers' exercise blood gases were normal and the chest x-ray showed no active pathology. He did not have hypoxia. Physical examination revealed decreased breath sounds bibasilar, no wheezing, no rhonchi, and a soft systolic murmur in the left sternal border. Dr. Ammisetty diagnosed Mr. Childers with "shortness of breath most probably due to cardiac origin." He noted that Mr. Childers had "significant" heart problems and right ventricle dilatation and that his pulmonary function test was adequately good.

Dr. Broudy treated Mr. Childers for a dyspnea evaluation on June 5, 2001. (DX 20, 14). Dr. Broudy recorded Mr. Childers' medical history, which included three knee replacements. Mr. Childers' knee pain led to inactivity, weight gain, and an increase in dyspnea. Mr. Childers reported shortness of breath walking short distances on level ground and going up less than one flight of stairs. Mr. Childers also had difficulty at night and sometimes had to get of out bed

because of shortness of breath. Mr. Childers denied other respiratory symptoms including cough, sputum production, hemoptysis, fever, chills, night sweats, weight loss, edema, or calf pain. Mr. Childers stated that he suffered from chest pain that he attributed to cardiac problems. Dr. Broudy recorded that Mr. Childers only smoked while in the service; however, Dr. Broudy reported an eighteen pack-year smoking history from a prior occupational pulmonary disease evaluation in 1989. Dr. Broudy also reported a seventeen year coal mine employment history with six years in underground coal mining. Mr. Childers' medications included Albuterol inhaler, Slo-Bid, Neurontin, Capoten, Lopid, Transderm-Nitro, Trental, Vistaril, Avandia, Diabeta, Calan-SR, Ultram, Desyrel, Allopurinol, Lasix, Reglan, Ambien, Prevacid, Vioxx, Lanoxin, Zyrtec, and baby aspirin. A physical examination revealed an obese male with unlabored aspirations. The chest expansion was clear to auscultation and percussion. Dr. Broudy did not find any cyanosis, clubbing, or edema of the extremities. He did note that Mr. Childers had a heart murmur along the lower left sternal border. Dr. Broudy performed a chest x-ray, pulmonary function test, and arterial blood gas study. The chest x-ray showed no evidence of pneumoconiosis. The pulmonary function test showed a mild restrictive defect with slight improvement after bronchodilation. The arterial blood gas study was normal. Dr. Broudy's assessment was non-pulmonary dyspnea, probably related to obesity, poor conditioning, and anemia. Dr. Broudy found that lung disease per se was not playing a major role in his dyspnea at the time of the examination.

DISCUSSION AND APPLICABLE LAW

Applicable Law

Entitlement to benefits must be established under the regulatory criteria at Part 718. *See Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988). The Act provides that benefits are provided to eligible survivors of a miner whose death was due to pneumoconiosis. § 718.205(a). In order to receive benefits, Claimant must prove that:

1. The miner had pneumoconiosis;

2. The miner's pneumoconiosis arose out of coal mine employment; and

3. The miner's death was due to pneumoconiosis.

§§ 718.205(a). Failure to establish any of these elements by a preponderance of the evidence precludes entitlement. *See Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26, 1-27 (1987). However, the Board has held that, in a survivor's claim under Part 718, the administrative law judge must make a threshold determination as to the existence of pneumoconiosis under 20 C.F.R. § 718.202(a) prior to considering whether the miner's death was due to pneumoconiosis. *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993).

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP, v. Greenwhich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those disease recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but it not limited to, coal workers' pneumoconiosis, anthraxcosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

§ 718.201(a).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). I may also assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Clark*, 12 B.L.R. 1-149 (1989).

Four chest x-rays were submitted for consideration. On February 1, 1990, Dr. Fisher reviewed the September 11, 1988, chest x-ray and found pneumoconiosis, Category 2/1. (DX 1). Dr. Mathur reviewed the February 13, 1990, chest x-ray on March 21, 1990. (DX 1). He found

pneumoconiosis, Category 1/2. (DX 1). Dr. Wiot reviewed the June 5, 2001, chest x-ray on March 7, 2003, and Dr. Spitz reviewed the same chest x-ray on September 17, 2004 (DX 19; EX 5). Both physicians interpreted the film as negative for pneumoconiosis. (DX 19; EX 5). All four reviewing physicians have the same qualifications; all are Board-certified radiologists and B-readers. There are two positive chest x-ray interpretations and two negative chest x-ray interpretations; thus, I find that the chest x-ray evidence is in equilibrium. As such, Claimant has failed to establish by a preponderance of the chest x-ray evidence that Mr. Childers suffered from pneumoconiosis § 718.202(a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based upon biopsy or autopsy evidence. There is no biopsy evidence to consider. There are autopsy reports in the record from four physicians: Drs. Dennis, Caffrey, DeLara, and Crouch.

Dr. DeLara also found deposits of black anthracotic pigment, emphysemateous changes, and coal macules. He described the fibrosis as "mild." At the end of his short report, Dr. DeLara wrote, "I hope this will help Mr. Childers [*sic*] family to get what they deserve." I give little weight to Dr. DeLara's report because his bias with regard to this claim is obvious.

Dr. Dennis was the prosector at Mr. Childers' autopsy. Dr. Dennis found minimal black pigment deposition with "very little" fibrosis. He determined that Mr. Childers died as a result of coronary artery disease, hypertensive cardiovascular disease with pulmonary congestion and edema. He noted only minimal evidence of black lung disease. Although I am entitled to give greater weight to Dr. Dennis' opinions because he performed the autopsy, *see Similia v. Bethlehem Mine Corp.*, 7 B.L.R. 1-535 (1984); *Cantrell v. U.S. Steel Corp.*, 6 B.L.R. 1-1003 (1984); *Gruller v. Bethenergy Mines, Inc*., 16 B.L.R. 1-3 (1991), I must accord his reports less weight because they are internally inconsistent and unreasoned. It is proper to accord little probative value to a physician's opinion which is inconsistent with his earlier report or testimony. *Hopton v. U.S. Steel Corp.*, 7 B.L.R. 1-12 (1984); *Surma v. Rochester & Pittsburgh Coal Co.*, 6 B.L.R. 1-799 (1984). *See also*, *Brazzale v. Director, OWCP*, 803 F.2d 934 (8th Cir. 1986) (a physician's opinion may be found unreasoned given inconsistencies in the physician's testimony and other conflicting opinions of record). In later reports, Dr. Dennis seemingly attempts to bolster his autopsy findings. He determined that Mr. Childers' had an occupational or chronic lung disease caused by coal mine employment. He determined that Mr. Childers' respiratory disease was enhanced in severity due to coal dust, yet he attributed only 5% of Mr. Childers' lung disease to coal dust exposure. Moreover, Drs. Caffrey and Crouch, who both reviewed the autopsy slides, are, at best, confused by Dr. Dennis' findings regarding "minimal evidence of black lung disease" and are, at worst, in complete disagreement with him. Although both Drs. Caffrey and Crouch found evidence of black pigment, neither found evidence of fibrosis, macules, or lesions associated with coal workers' pneumoconiosis. I afford the opinions of Drs. Caffrey and Crouch greater weight because they are well-reasoned, well-documented, and consistent. Therefore, I find that Claimant has failed to establish the existence of pneumoconiosis through biopsy or autopsy evidence under § 718.202(a)(2).

(3) Under § 718.202(a)(3), pneumoconiosis may be established if any one of the several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of §

718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish the existence of pneumoconiosis under § 718.202(a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4), which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, nothwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not Claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned medical opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). A report may be adequately documented if it is based on items such as a physical examination, symptoms, and a patient's history. *See Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co*.,7 B.L.R. 1-295 (1984); *Buffalo v. Director, OWCP*, 6 B.L.R. 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp.*, 2 B.L.R. 1-130 (1979). Consideration must be given to the relationship between the miner and any treating physician whose report is admitted into the record. 20 C.F.R. § 718.104(d). Specifically, the following factors must be considered when weighing the opinion of the miner's treating physician: (1) nature of relationship, (2) duration of relationship, (3) frequency of treatment, and (4) extent of treatment. "[T]he opinions of treating physicians are not necessarily entitled to greater weight than those of non-treating physicians in black lung litigation." *Eastover Mining Co. v. Williams*, 338 F.3d 501 (6th Cir. 2003). "[I]n black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade." *Id*. at 510; 20 C.F.R. § 718.104(d). "A highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinion appropriately discounted." *Id*. In addition, appropriate weight should be given as to whether the treating physician's report is well-reasoned and well-documented. *See Peabody Coal Co. v. Groves*, 277 F.3d 829 (6th Cir. 2002); *McClendon v. Drummond Coal Co.*, 12 B.L.R. 2-108 (11th Cir. 1988).

I must consider Dr. Gibson's medical reports. Dr. Gibson treated Mr. Childers regularly for nearly nineteen years. Dr. Gibson's duration and frequency of treatment were sufficient to consider giving his opinion additional probative weight. However, I find that his opinion is entitled to lesser weight even when considered in conjunction with his hospitalization records and treatment notes. Dr. Gibson mainly treated Mr. Childers for a heart condition, knee pain, and the occasional cold and flu. The main purpose of his visits did not appear to be respiratory or pulmonary in nature. Dr. Gibson failed to obtain superior and relevant information regarding Mr. Childers' respiratory or pulmonary condition because, in nearly nineteen years, he did not obtain extensive objective testing or conduct extensive respiratory examinations. Furthermore, Dr. Gibson's opinions are neither well-documented nor well-reasoned. Dr. Gibson failed to record Mr. Childers' medical history, smoking history, coal mine employment history, or family history. He did not obtain any objective medical evidence such as chest x-ray, pulmonary function tests, or arterial blood gas studies, and he did not note any physical examination results to support his conclusions. Dr. Gibson noted the presence or absence of edema in his cardiac check-ups. Finally, Dr. Gibson was inconsistent between his treatment notes and his written medical reports. In his written medical reports, he continually diagnosed coal workers' pneumoconiosis or an occupational lung disease caused by his coal mine employment. On occasion in his treatment notes, Dr. Gibson reported a diagnosis of chronic obstructive pulmonary disease with no mention of pneumoconiosis. The remaining hospitalization records and treatment notes also do not reflect a diagnosis of pneumoconiosis. Hence, I find that Claimant has not established that her husband suffered from pneumoconiosis pursuant to § 718.202(a)(4).

I am aware that other administrative law judges found and the Benefits Review Board affirmed that Mr. Childers established the element of pneumoconiosis in his living miner's claim. However, the doctrine of collateral estoppel does not apply in this survivor's claim. The following requirements must be satisfied prior to application of collateral estoppel or issue preclusion. The issue to be precluded must be (1) the same as that involved in the prior action, (2) actually litigated in the prior action, and (3) essential to the final judgment in the prior action. Two additional requirements must also be met, (1) the party against whom estoppel is invoked must have been fully represented in the prior litigation, and (2) the parties in both actions must be the same or in privity. The issue to be precluded here, i.e. whether Mr. Childers' had pneumoconiosis, is the same as involved in his living miner's claim. That issue was actually litigated in the prior action because the parties presented evidence and an administrative law judge determined that Mr. Childers proved by a preponderance of the evidence that pneumoconiosis existed.[15] I note, however, that Mr. Childers' prior claims were denied because he failed to established total disability, which is an essential element of entitlement. Furthermore, the issue of pneumoconiosis was not the essential element. Stated another way, while pneumoconiosis was a threshold issue to a final determination on whether Mr. Childers was totally disabled due to pneumoconiosis in the living miner's claim, it was not the essential issue to the final judgment in those claims. His failure to prove total disability, in and of itself, precluded an award, and thus, the issue of pneumoconiosis had no bearing on the final judgment.

[15] It is important to note that there was no autopsy in the living miner's claim. Autopsy evidence is the most reliable evidence of the existence of pneumoconiosis. *Terlip v. Director, OWCP*, 8 B.L.R. 1-363 (1985). *See also Peabody Coal Co. v. McCandless*, 255 F.3d 465 (7th Cir. 2001).

Claimant's failure to prove the existence of pneumoconiosis by a preponderance of the evidence precludes entitlement. Because pneumoconiosis is a threshold requirement to the entitlement analysis, I need not consider or determine the remaining elements of entitlement.

Entitlement:

Claimant, Baszella Childers, has failed to prove that her husband, Vernon Childers, suffered from pneumoconiosis. Because she has failed to establish an essential element of entitlement, Mrs. Childers is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which Claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of Baszella Childers for benefits under the Act is hereby DENIED.

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THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board (Board). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C. 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, D.C. 20210. *See* 20 C.F.R. § 725.481. If an appeal is not

timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).